

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN6101 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 08/08/2012 |
| NAME OF PROVIDER OR SUPPLIER BROOKWOOD NURSING CENTER, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETE DATE |
| N 000 | Initial Comments Complaint investigation #29348, #29588, and #29571, were completed at Brookwood Nursing Center on August 8, 2012. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes. | N 000 | | | |

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6599

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If continuation sheet 1 of 1